

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2012
NAME OF PROVIDER OR SUPPLIER HOWARD REGIONAL HEALTH SYSTEM		STREET ADDRESS, CITY, STATE, ZIP CODE 3500 S LAFOUNTAIN ST KOKOMO, IN 46904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of a State hospital complaint.</p> <p>Complaint Number: IN00102179</p> <p>Unsubstantiated: lack of sufficient evidence</p> <p>Date: 4/3/12 and 5/10/12</p> <p>Facility Number: 005007</p> <p>Surveyor: Jacqueline Brown, R.N. Public Health Nurse Surveyor</p> <p>Howard Regional Health System is in compliance with 410 IAC 15-1.5-2, Infection control and 410 IAC 15-1.5-8, Physical plant, Indiana Hospital Licensure Rules.</p> <p>QA: cloughlin 06/14/12</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

Z6SX11

If continuation sheet 1 of 1